Provider Agreement

PIN:

Connecticut Vaccines For Children Program

I certify that in administering the vaccine I/we receive from the Connecticut Vaccines for Children (VFC) program for use in this facility that:

1. **I/We will not impose a charge for the cost of the vaccine received through this program**. I/We may, however, charge a reasonable administration fee per dose given, but these fees should not exceed the **$21.00 per dose** fee cap established by the State Immunization Program. Out of pocket costs for well-child care that includes immunization should be kept to a minimum, and a provider using vaccines supplied through the VFC program **may not deny** services to a child whose family cannot pay an administration fee or make a donation to a provider. In addition, providers may not bill a third party (e.g. insurance company or Medicaid) for vaccines already purchased with public (including VFC) funds. However, a provider may bill an insurance company for vaccine administration fees in excess of the $21.00 fee cap up to the maximum allowable per the company's policy. For the purpose of this agreement, multiple antigens such as MMR, MMRV, Td, DTaP, TDaP, and DTaP/IPV/HepB are considered to be one vaccine. In the event that the vaccine recipient is a Title XIX (Medicaid) recipient, fee schedules established by the Department of Social Services will prevail. **Imposition of a charge for the cost of the vaccine is considered a fraudulent offense and could result in criminal charges.**

2. I/We agree to provide the Connecticut Immunization Program with the numbers of children 0-18 years of age expected to need immunizations at this facility/practice for the 12 month period beginning on July 1, 2007. I/We will screen patients at all immunization encounters for eligibility and administer VFC vaccine to those children 18 years of age and younger who meet one or more of the following criteria: (A) enrolled in the Medicaid Program (or qualifies through a State's Medicaid waiver), (B) has no health insurance, (C) are American Indians or Alaskan natives, (D) has health insurance that does not pay for vaccinations (only applicable to FQHCs or RHCs), or (E) are none of the above. I/We will provide this information on the form entitled PROVIDER PROFILE as part of the procedure to enroll in the Connecticut VFC Program to receive publicly purchased vaccines.

3. I/We will comply with the current immunization schedule, dosage, and contraindications, that are established by the DHHS Advisory Committee on Immunization Practices (ACIP) or the Report of the Committee on Infectious Diseases of the AAP, and included in the VFC Program unless (a) in my medical judgement, and in accordance with accepted medical practice, I deem such compliance to be medically inappropriate; or (b) the particular requirement contradicts the Connecticut law, including Connecticut laws relating to religious or other exemptions.

4. I/We will provide a copy of the most current "Vaccine Information Statement" (VIS) each time a vaccine is administered to the vaccine recipient or legal guardian. I/We understand that these forms are designed to notify the vaccinee of the risk and benefits associated with receiving the vaccine and may provide me/us liability protection in the event that the vaccinee suffers a severe adverse reaction to the vaccine. I/We further understand that these materials meet the requirements for providers of vaccines covered by the National Vaccine Injury Compensation Program. As required by federal law, I/we will record on the patient's permanent medical record (or in a permanent office log or file) for a period **10 years** following the end of the calendar year the information* listed below:
   - * Date vaccine is administered;
   - * Name, address, professional title and signature of person administering the vaccine. (This information may be recorded one time. Use a single sheet or as many sheets as needed to record the required identifying information regarding the individual(s) administering vaccine at the facility/practice. The sheet(s) will need to be maintained in the office and be retrievable on request by the Immunization Program. Thereafter, the signature of the individual administering the vaccine, which will be entered on the patient's permanent medical record, will serve to satisfy the requirements related to the identification of the individual administering the vaccine.);
   - * Manufacturer's name and lot number of the vaccine and the route and site the vaccine was administered (e.g. oral or IM, right thigh or left arm, etc).

5. I/We will maintain all VFC-related records for a period of **three** (**3**) **years**. Release of such records will be bound by the privacy protection of Federal Medicaid law. If requested, I/we will make such records available to the Connecticut Immunization Program or the U.S. Department of Health and Human Services (DHHS).

6. I/We will comply with the Immunization Program requirements for ordering vaccines and with other requirements as outlined on the Vaccine Order Form (VOF) including the reporting of doses of vaccine administered by broad age categories and by dose number in the series on the order form provided by the Immunization Program. I/We will maintain good vaccine handling and storage practices and will report to the Immunization Program any vaccine wastage/loss. I/We agree to operate the VFC program in a manner intended to avoid fraud and abuse.

7. I/We will report adverse reactions (reactions requiring medical attention) associated with vaccine. Report reactions to (860) 509-7929.

8. I/We understand that the Connecticut Immunization Program reserves the right to visit the facility. I/We will allow periodic inspections of vaccine supplies and records by the Connecticut Immunization Program.

9. Either the Connecticut Immunization Program may terminate this agreement at any time for failure to comply with these requirements or I/We may terminate this agreement for personal reasons. I/We agree to properly return any unused VFC vaccine upon termination of this agreement.

_____ _____

Provider Signature Date

This record is to be submitted to and kept on file at the Connecticut Immunization Program and must be updated at least once annually. A copy of this form will be retained at the provider's office. It will be shared with all relevant persons at the facility/practice including persons administering vaccines, staff responsible for billing procedures and any others determined at the provider site that need to know the information herein.